

[Insert University Logo and Address/Phone Here]

### Assignment of Support Provider

\_\_\_\_\_ is in the process of entering the Level II Education Specialist program at \_\_\_\_\_. One requirement for entering this program is that the employing education agency must assign a Support Provider to support the new special education teacher. The Support Provider will assist the teacher with activities that facilitate the professional development and effective performance of the teacher.

The Support Provider must be selected based upon her/his professional experience, coaching skills, and knowledge of the profession, as well as her/his ability to provide for the individual needs of the candidate. The assigned Support Provider must hold a current teaching credential authorizing them to teach in the area covered in the teacher's classroom and must have at least three years of teaching experience. The assignment must be agreed to by the employing district, service provider, institutional faculty advisor, and candidate.

The teacher's employer should review the required competencies included with this form (see Individualized Induction Plan) and select a Support Provider who both meets criteria above and who is capable of effectively supporting the teacher in the competency areas.

Candidate \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ e-mail \_\_\_\_\_

#### *Candidate's Professional Position*

School District/Agency \_\_\_\_\_ School/Location \_\_\_\_\_

Job Title \_\_\_\_\_ Start Date \_\_\_\_\_

phone \_\_\_\_\_ e-mail \_\_\_\_\_

#### *Support Provider*

Name \_\_\_\_\_ School/Location \_\_\_\_\_

Job Title \_\_\_\_\_ Date Designated as Support Provider \_\_\_\_\_

Credentials Held \_\_\_\_\_

#### *Signatures of Support Provider and School/Agency Official*

I agree to work with the assigned faculty person from \_\_\_\_\_ to provide direction and support for the professional development of the above Professional Level II Education Specialist Credential Program candidate

Signature \_\_\_\_\_ Date \_\_\_\_\_

I affirm that the Support Provider is a credentialed staff member and not the supervisor or principal for the candidate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (Please print) \_\_\_\_\_ Title \_\_\_\_\_

Phone \_\_\_\_\_ e-mail \_\_\_\_\_

University Supervisor \_\_\_\_\_ Title \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

COPIES OF THIS FORM SHOULD BE FILED WITH THE EMPLOYER AND UNIVERSITY